MAP-130

PRIOR AUTHORIZATION (PA) FAX-FORM INSTRUCTIONS
Kentucky Medicaid Home Health Care Services
January 22, 2008

Indicate reason the PA request is being submitted.

Please list the start date of the recipient's plan of care and the date the CMS 485 Home Health Certification and Plan of Care was completed.

Patient Information – In this section, list all the pertinent personal information of the Home Health (HH) recipient.

EPSDT - If recipient is a child under age 21, services and supplies appropriate to the EPSDT program should be requested under EPSDT program requirements.

Responsible Party- If the recipient is a child under the age of 18, or an adult that has a responsible party, please enter the required information.

Homebound Status – Consideration of the recipient's medical and mental condition, functional limitations and degree of difficulty in accessing medical care, and the services to be provided, shall be considered to determine if it is reasonable to request Medicaid reimbursement for HH services*. Outpatient services, including physician office or clinic visits, should be utilized when the recipient is medically able to do so.*
Explanation related to homebound status is not required for "supply only" recipients. The PA approval for "supply only" is ninety (90) days.

Include the most recent date last seen by the primary physician. (According to clinical records or recipient's recollection).

Recipient Diagnosis – It is imperative to list the recipient's pertinent primary and secondary diagnoses code, description and onset date**. List all diagnoses relative to the services and supplies requested.**

Caregiver information - If there is not a reliable caregiver, provide documentation for recipient self care and necessary HH intervention.

If recipient has been discharged from your Home Health Agency (HHA), give date of discharge and reason.

Personal Care Home (PCH) **-** If recipient is a resident of a PCH, give the name and address of the PCH. **Personal Care is not approved for PCH residents** (Revenue code 570).

Primary Physician Information – Complete the information for the physician who is responsible for medical care of the recipient. Include: primary physician name, address, UPIN, telephone number, and verify if there is a physician order for all requested services and/or supplies. (S*igned and dated physician order(s) required within 21 days of receiving order(s).*

Agency Information – List the HHA name, address, person in the agency requesting the PA, *and a contact name if different than the requestor,* telephone, fax and provider number. **(Instructions continue on page 2)**

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List the Home Health Care services you are requesting: explain the type, frequency, duration, number of visits, start and end date of the Plan of Care.

Wound care – The Physician's order, as is written and a description of the wound(s) are required. May continue on " Other Clinical Documentation" section if necessary.

Provide clinical supporting documentation and appropriate diagnoses to justify and validate "Medical Necessity" for all requests of gloves, nutritional supplements, and incontinent supplies.

Gloves – used for the protection of the caregiver are NOT to be authorized.
Approved coverage examples (*not all inclusive)***:** wound care, trach care, IV site care, in & out cath care, immune suppressed, (new or infected, g-tube, ileostomy, and colostomy site care within the first 60 day plan).

Nutritional Supplements – must be part of the HH Plan of Care/Treatment which includes an approved HH service. Nutritional supplements are covered for the following diagnoses and/or conditions-disorders of significant mental or physical health including trauma, significant weight loss, chronic and/or acute illness which have been determined to require nutritional supplements in order to maintain optimum health status and adequate weight.
Approved coverage examples (*not all inclusive)***:** Cancer, Dyspnea related to moderate/severe Pulmonary or Cardiac Disease, Renal Failure, Dysphagia, Wounds, Burns, Alcohol Abuse, Substance Abuse, Gastrointestinal and/or Bowel Impairment, Mal-absorption Impairments, Failure to Thrive, Anorexia, Bulimia, and Hyperkinesis associated with diseases such as: Parkinson's disease, Huntington's chorea or Cerebral Palsy.
Including, but not limited to, conditions- disorders:
Abnormal labs, Albumin, Total iron binding capacity, Decreased appetite due to side effect of medication, Metabolic or Electrolyte Disorders, Psychological Disorders impairing food intake such as Depression.

Total nutritional products must be requested through the DME program.

Incontinent supplies – The recipient must be greater than 36 months of age.
A diagnosis of incontinence and a diagnosis related to incontinence are required. Also required is a description of the type of incontinence, i.e. Bladder &/or Bowel control problems, Stress, Overflow, Nocturia, Urinary urge and Urinary retention. **Each recipient's needs must be evaluated for type and quantity or combination of incontinent supplies.**

Other Supporting Clinical Documentation - List other pertinent information for recipient's care needs not detailed in any other category. HHA must **justify and validate "Medical Necessity"** for all requests.

Disposable medical supplies and supplements – List the medical supplies and supplements that are required to treat the recipient's illness/injury. **Exclude all administrative supplies.**